Pediatric Potentials, LLC
Occupational Therapy Services

NEW PATIENT INFORMATION SHEET

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) ____

Address: (No., Street) _____

(City) _____ (State) _____ (ZIP) _____

Social Security #: _____ Please include this for billing purposes.

Date of Birth: _____ **Age:** _____ **Sex:** □ M □ F

Diagnosis: _____

Referring Physician: _____

RESPONSIBLE PARTY / INSURED INFORMATION

Relationship to Patient: □ Parent □ Other _____

Name: (Last) _____ (First) _____ (MI) ____

Social Security # (of responsible party)_____

DOB (of responsible party) _____

Address: (No., Street) _____

(City) _____ (State) _____ (ZIP) _____

Phone #: _____ **Cell Phone #:** _____

Email: _____

Pediatric Potentials Occupational Therapy Services, LLC
1122 East Main Street, Suite 4 ● Bozeman, MT 59715 ● Tel. (406) 582-4182

INSURANCE INFORMATION

☐ **Cash**

☐ **Private Insurance** (Company) _____

☐ **Private Insurance** (Company) _____ **Medicaid 2d** (Policy #) _____

☐ **Medicaid Primary** (Policy #) _____

AUTHORIZATION

I authorize the release of any medical information to Pediatric Potentials, LLC needed to process an insurance claim for services rendered. This authorization shall remain valid until written notice is given by me revoking said authorization.

Patient's or Responsible Party's Signature

_____ Date: _____

I hereby assign, transfer, and set over to Pediatric Potentials, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. This authorization shall remain valid until written notice is given by me revoking said authorization.

Patient's or Responsible Party's Signature

_____ Date: _____

PAYMENT

I understand that I am financially responsible for all charges due upon completion of service; and that there is a $25 fee for cancelling without notice. Should my account be referred to an outside collections agency, I agree to pay all collection costs, attorney fees and court costs.

Patient's or Responsible Party's Signature

_____ Date: _____